CHAPTER 2

THE CERTIFICATION PROCESS

Hospices

Hospices

2080. HOSPICE - CITATIONS AND DESCRIPTION

A. Citations.--Section 1861(u) of the Act created hospices as a provider category. Section 1861(dd) of the Act defines hospice care and the hospice program. 42 CFR 418 sets forth the CoPs. 42 CFR Part 418.100 is an additional Condition applicable only to hospices that provide short-term inpatient care and respite care directly, rather than under arrangements with other participating providers. Section 1866(a)(1)(Q) of the Act, as added by §4206(a)(1)(C) of OBRA 1990, P.L. Number 101-508, requires hospices, among other providers, to file an agreement with the Secretary to comply with the requirements found in §1866 of the Act regarding advance directives.

B. Description.--Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and uncomfortable symptoms), as opposed to curative care. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family/caregiver. The emphasis of the hospice program is on keeping the hospice patient at home with family and friends as long as possible.

Although some hospices are located in hospitals, SNFs, and HHAs, hospices must meet specific CoPs and be separately certified and approved for Medicare participation. (See Exhibit 129 for Hospice Survey and Deficiencies Report, Form HCFA-643 and Exhibit 72 for Hospice Request for Certification in the Medicare Program, Form HCFA-417.)

C. Services and Items Provided.--Substantially all core services must be provided directly by hospice employees on a routine basis. A hospice may use contracted staff for core services only under extraordinary circumstances (i.e., to supplement hospice employees in order to meet patients' needs during periods of peak patient load.) If contracting is used, the hospice must continue to maintain professional, financial, and administrative responsibility for the services.

The following are hospice core services and must be provided directly by hospice employees:

- Nursing care provided by or under the supervision of an RN functioning within a medically approved plan of care;
- Medical social services under the direction of a physician;
- Physician's services; and

- Counseling (including dietary and bereavement counseling) with respect to care of the terminally ill individual and adjustment to death.

When included in the patient's written plan of care, the following services must be available as needed and provided by the hospice, either directly or under arrangements made by the hospice:

- Physical and occupational therapy and speech-language pathology services;

- Home health aide services. A home health aide employed by a hospice, either directly or under a contract, must meet the personnel qualifications specified in 42 CFR Part 484.4 for "home health aide" and must meet all the training, attitude, and skill requirements for a home health aide working in an HHA, as specified in 42 CFR Part 484.36;

- Homemaker services;

- Medical supplies (including drugs and biologicals) and the use of medical appliances related to the terminal diagnosis;

- Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in a Medicare/Medicaid approved inpatient facility; and

- Continuous home care provided for a period of 8 or more hours in a day during a period of crisis, and only as necessary to maintain the patient at home. It consists predominantly of nursing care, but may also include homemaker services, home health aide services, and other disciplines.

In addition, the statute stipulates other specific requirements including a limitation on the proportion of inpatient days for hospice patients and a prohibition against discontinuing or diminishing services for Medicare beneficiaries unable to pay for hospice care.

Hospices must maintain professional management and financial responsibility for services provided under arrangements, regardless of the location or facility in which such services are furnished.

If a hospice is established by an entity which participates in the Medicare program as another type of provider (hospital, SNF, HHA), the SA should attempt to coordinate simultaneous certification surveys of these entities, i.e., for compliance with hospice CoPs and for compliance with the other appropriate

CoPs.

NOTE: Section 1861(dd)(4)(A) of the Act states that if a hospice is approved as being part of another type of provider, with a separate provider number, it shall be considered to meet those CoPs that are common to both the hospice and the other type of provider.

2081. HOSPICE - MULTIPLE LOCATIONS

Neither the statute nor the hospice regulations provides for establishing hospice "satellite" offices. Nonetheless, a hospice is not precluded from providing services at more than one location if certain requirements assuring quality of care are met and these locations are approved by the RO. The RO, in order to support HCFA's responsibility to protect the Medicare trust fund against excessive and unnecessary costs, will also ensure that the locations promote cost effective health care. This includes reimbursing hospices at a rate that has been established for the local area. The RO will make a final determination on both quality and cost effectiveness issues with the assistance of the State agency and the fiscal intermediary, if necessary, and will notify all parties of its decision.

To support our concern for quality, HCFA requires a hospice who provides services at more than one location, to comply with the following:

- The hospice must be able to exert the supervision and control necessary at each location to assure that all hospice care and services continue to be responsive to the needs of the patient/family at all times and in all settings. Hospice care requires the closest of interventions and a distant "parent" cannot provide the immediate access needed to ensure health and safety.

- Each location must provide the same full range of services that is required of the hospice issued the provider number;

- Each location must be responsible to the same governing body and central administration that governs the hospice issued the provider number, and the governing body and central administration must be able to adequately manage the location and assure quality of care at the location; and

o All hospice patients' clinical records requested by the surveyor must be available at the hospice site issued the provider number.

If a proposed hospice location does not meet the above criteria for quality and cost effectiveness, it must seek Medicare approval as a separate hospice with its own provider agreement and provider number.

If the hospice does operate at multiple locations, a deficiency found at any location will result in a compliance issue for the entire hospice.

2082. ELECTION OF HOSPICE BENEFIT BY RESIDENT OF SNF, NF, ICF/MR, OR NON-CERTIFIED FACILITY

There is no indication in the statute that the term "home" is to be limited for a hospice patient. A patient's home is where he or she resides. A hospice may furnish routine or continuous home care to a Medicare beneficiary who resides in a SNF, NF, ICF/MR, or any residence or facility not certified by Medicare or Medicaid. The facility is considered to be the beneficiary's place of residence (the same as a house or apartment), and the facility resident may elect the hospice benefit if he/she also meets the hospice eligibility criteria. The hospice then assumes full responsibility for professional management of the individual's hospice care in accordance with the hospice CoPs and makes any arrangements necessary for inpatient care in a participating Medicare or Medicaid facility.

A. Compliance With SNF/NF CoPs.--The SNF/NF CoPs are applicable to all of the residents in a SNF/NF facility. Neither the statute nor the regulations setting out SNF/NF requirements exempt hospice patients in a SNF/NF from those regulations. Sections 1819(c)(4) and 1919(c)(4) provide that a SNF or NF must "establish and maintain identical policies and practices" regarding transfer, discharge, and the provision of covered services under Medicare or Medicaid "for all individuals regardless of source of payment."

Sections 1819 and 1919 of the Act set forth requirements for SNFs and NFs to ensure that these facilities provide quality care and services to their residents. Even though the SNF/NF is the hospice patient's residence for purposes of the hospice benefit, the SNF/NF must still comply with all SNF/NF Requirements for participation in Medicare or Medicaid. This means that the resident must be assessed using the information contained in the Resident Assessment Instrument (RAI) (which includes both the Minimum Data Set (MDS) and the Resident Assessment Protocols (RAPs)), have a plan of care, which, in this case, will be jointly developed with and agreed upon by the hospice, and be provided with all services contained in the plan of care. The plan of care must be consistent with the hospice philosophy of care.

When a resident of a Medicare/Medicaid participating SNF/NF elects the Medicare hospice benefit, the hospice and the SNF/NF must communicate, establish, and agree upon a coordinated plan of care

for both providers which reflects the hospice philosophy, and is based on an assessment of the individual's needs and unique living situation in the SNF/NF. The plan of care must be written in accordance with 42 CFR Part 418.58 and include the individual's current medical, physical, psychosocial, and spiritual needs. The hospice must designate an RN from the hospice to coordinate the implementation of the plan of care. (See 42 CFR 418.68(d).)

This coordinated plan of care must identify the care and services which the SNF/NF and hospice will provide in order to be responsive to the unique needs of the patient/resident and his/her expressed desire for hospice care. The plan of care must include directives for managing pain and other uncomfortable symptoms and be revised and updated as necessary to reflect the individual's current status.

The SNF/NF and the hospice are responsible for performing each of their respective functions which have been agreed upon and included in the plan of care. The hospice retains overall professional management responsibility for directing the implementation of the plan of care. In addition:

- o All covered hospice services must be available as necessary to meet the needs of the patient;

- o Substantially all core services must be routinely provided directly by hospice employees and cannot be delegated to the SNF/NF. (See 42 CFR Part 418.80);

- o Drugs and medical supplies must be provided as needed for the palliation and management of the terminal illness and related conditions. Drugs must be furnished in accordance with accepted professional standards of practice. (See 42 CFR Part §418.96); and

- o The plan of care should reflect the participation of the hospice, SNF/NF, and the patient to the extent possible. The hospice and the SNF/NF must communicate with each other when any changes are indicated to the plan of care, and each provider must be aware of the other's responsibilities in implementing the plan of care.

Evidence of this coordinated plan of care must be present in the clinical records of both providers. All aspects of the plan of care should reflect the hospice philosophy.

The SNF/NF services must be consistent with the plan of care developed in coordination with the hospice. The hospice patient residing in a SNF/NF should not experience any lack of SNF/NF services or personal care because of his/her status as a hospice patient. The plan of care must include directives for managing pain and other uncomfortable symptoms and be revised and updated as necessary to reflect the individual's current status. The SNF/NF must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The patient/resident has the right to refuse any services.

B. Professional Management.--The use of the term "professional management" for a hospice patient who resides in a SNF/NF should have the same meaning to a hospice that it would have if the hospice patient were living in his/her own home. The professional services usually provided by the hospice to the patient in his/her home should continue to be provided by the hospice to the resident in a SNF, NF, or other place of residence. This includes furnishing any necessary medical services to those patients that the hospice would normally furnish to patients in their homes. In addition, substantially all hospice core services (physician services, nursing services, medical social services, and counseling) must be routinely provided directly by hospice employees and cannot be delegated. The hospice may involve the SNF/NF nursing personnel in assisting with the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of a hospice patient's family/caregiver in implementing the plan of care. (For example,

SNF/NF staff who are permitted by the facility and by law may assist in the administration of medication as established by the plan of care developed by the hospice interdisciplinary group (IDG), in coordination with the SNF/NF.)

C. Provision of Non-Core Services To SNF/NF Residents.--The hospice may arrange to have non-core hospice services provided by the SNF/NF if the hospice assumes professional management responsibility for these services and assures that these services are performed in accordance with
the policies of the hospice and the patient's plan of care. (See 42 CFR Part §418.56.)

D. SNF/NF Residents and Dually-Eligible Beneficiaries.--A Medicare beneficiary who resides in a SNF/NF may elect the hospice benefit when the residential care is paid for by the beneficiary.
A Medicare beneficiary who is also eligible for Medicaid and whose NF care is being paid for by Medicaid may also elect the Medicare hospice benefit if the hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual. The hospice patient must remain in a Medicaid certified bed while residing in the NF. The SMA pays the hospice the amount determined as payment for room and board while the patient is receiving hospice care, and the hospice pays the facility. Room and board services include:

- Performing personal care services;
- Assisting with activities of daily living;
- Administering medication;
- Socializing activities;
- Maintaining the cleanliness of a resident's room; and
- Supervising and assisting in the use of DME and prescribed therapies.

In States that offer the Medicaid hospice benefit, and an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked under both programs, and each program notified as to the patient's decision.

2083. HOSPICE REGULATIONS AND NON-MEDICARE PATIENTS

The hospice CoPs apply to all patients of the hospice (Medicare and non-Medicare), with the exception of the following regulations, which apply only to Medicare beneficiaries:

42 CFR Part 418.60 - the continuation of care requirement; and

42 CFR Part 418.98(c) - the 80-20 inpatient care limitation.

2084. HOSPICE INPATIENT SERVICES FURNISHED DIRECTLY OR FURNISHED UNDER ARRANGEMENTS

Hospices must make inpatient care available for pain control, symptom management, and respite purposes. This inpatient care may be provided directly by the hospice, or indirectly under arrangements made by the hospice. If services are provided under arrangements, the hospice must ensure that the services are in full compliance with all applicable standards relating to inpatient care.

A. Hospice Provides Inpatient Care Directly.--If a hospice provides inpatient care directly, either in owned or leased space in another facility, the inpatient location must be surveyed for compliance with 42 CFR Part 418.100. The leased inpatient unit may consist of several beds, a group of beds, or a wing.

B. Hospice Provides Inpatient Services Under Arrangements.--When inpatient services are being provided under arrangements with a Medicare participating hospital or SNF, a Medicaid participating NF (for respite care only), or an inpatient unit of another hospice, a separate survey of each site is not required. In these cases, the SA reviews the agreement and patient files to assure that standards in 42 CFR Part 418.100(a) (24-hour nursing service) and (**e**) (comfort and privacy of patient and family members) are satisfied. However, if in reviewing contracts and other documentation (e.g., clinical records, plans of care), questions arise concerning the contract arrangements, the SA conducts an onsite visit to the institution providing the inpatient services. This includes hospitals that are accredited by the JCAHO or AOA that are providing inpatient services under arrangements.

C. Hospice Provides Inpatient Services in Space Shared With Medicare-Approved Hospital or SNF at Same Location.--When inpatient services are provided at a location also approved as a SNF or hospital (dual or multiple certification), the SA inspects for compliance with 42 CFR Part 418.100(a) and (e).

APPLICABILITY OF INPATIENT CARE CoP
42 CFR Part 418.100

LOCATION WHERE INPATIENT CARE IS PROVIDED	APPLICABILITY OF CONDITION
Hospice inpatient unit	Survey for compliance with 42 CFR Part 418.100.
Medicare-approved hospital or SNF under arrangements with hospice	Survey for compliance with 42 CFR Part 418.100(a) and 418.100(e). Review both the agreement between the contracting parties and patient records to assure that the hospice arrangements are in compliance with the regulations. The institution already meets the remaining requirements of 42 CFR Part 418.100 as a Medicare-approved hospital or SNF. Do not inspect the hospital or SNF.
Hospice dually certified as hospital or SNF and as a hospice	Survey for compliance with 42 CFR Part 418.100(a) and 418.100(**e**).

	The institution already meets the remaining requirements of 42 CFR Part 418.100 as a Medicare-approved hospital or SNF.
Medicaid-approved NF (respite care only)	Survey for compliance with 42 CFR Part 418.100(a) and 418.100(**e**).

2085. OPERATION OF HOSPICE ACROSS STATE LINES

The provision of services across State lines is appropriate in most circumstances. Areas in which community services, such as hospitals, public transportation, and personnel services are shared on both sides of State boundaries are most likely to generate an extension of services.

When a hospice provides services across State lines, it must be certified by the State in which its provider number is based, and its personnel must be qualified in all States in which such personnel provide services. Each respective SA must be aware of and approve the action. The involved States should have a reciprocal agreement, either verbal or written, permitting the hospice to provide services in this manner. The SA must verify that each State's applicable personnel licensure and other requirements are met.

2086. HOSPICE HOME VISITS

The SA makes home visits to a sample of Medicare/Medicaid hospice patients during a hospice survey, if any of six conditions exist. Refer to Appendix M, Part III, Task 3.B. for complete instructions. (See model consent for hospice home visit form (Exhibit 128).)

2087. COMPLIANCE WITH ADVANCE DIRECTIVES

Under §§1866(a)(1)(Q) and 1902(a)(57) of the Act, a hospice is required to be in compliance with all Federal requirements in §§1866(f)(1) and 1902(w) of the Act, respectively, concerning advance

directives. Specifically, a hospice must agree to maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the hospice and must, at the time of initial receipt of hospice care by the individual from the program:

- Provide the individual with written information concerning his or her rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

- Provide the individual with the hospice's written policies and procedures concerning the implementation of such rights;

- Document in the individual's medical record whether he/she has executed an advance directive;

- Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

- Ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) concerning advance directives; and

- Provide (individually or with others) for education of staff and the community on issues concerning advance directives.

The facility is not required to provide care that conflicts with an advance directive. In addition, the facility is also not required to implement an advance directive if, as a matter of conscience, the facility cannot implement an advance directive and State law allows the provider to conscientiously object.

Compliance with the advance directives requirements is necessary for continued participation in the Medicare and Medicaid programs.